TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Steve Sacks MD

Respondent Name
Hidalgo County

MFDR Tracking Number
M4-15-3300-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $148.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. Upon review it was determined that the submitted bill was paid correctly per the fee schedule and guidelines."

Response Submitted by: Injury Management Organization, Inc 10255 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2014	Professional Services	$148.82	$121.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;"

   Review of the submitted information finds the submitted code, A4556, is considered a bundled code. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. The carrier applied reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment" to the remaining services in dispute. 28 Texas Administrative Code §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)."

   The maximum allowable reimbursement will be calculated as follows:

   - Procedure code 99204, service date September 25, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2.43. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 0.916 is 1.82284. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.816 is 0.17952. The sum of 4.43236 is multiplied by the Division conversion factor of $55.75 for a MAR of $247.10.
   - Procedure code 95886, service date September 25, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.916 is 1.52972. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.816 is 0.03264. The sum of 2.42236 is multiplied by the Division conversion factor of $55.75 for a MAR of $135.05 at 2 units is $270.10.
   - Procedure code 95913, service date September 25, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3.56 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3.56. The practice expense (PE) RVU of 4.82 multiplied by the PE GPCI of 0.916 is 4.41512. The malpractice RVU of 0.21 multiplied by the malpractice GPCI of 0.816 is 0.17136. The sum of 8.14648 is multiplied by the Division conversion factor of $55.75 for a MAR of $454.17.

3. The total allowable reimbursement for the services in dispute is $971.37. This amount less the amount previously paid by the insurance carrier of $850.30 leaves an amount due to the requestor of $121.07. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $121.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $121.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.